

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/29/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 290003		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/06/2010	
NAME OF PROVIDER OR SUPPLIER SUNRISE HOSPITAL AND MEDICAL CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3186 S MARYLAND PKWY LAS VEGAS, NV 89109			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
A 000	<p>INITIAL COMMENTS</p> <p>This Statement of Deficiencies was generated as a result of a Federal Complaint Validation Survey conducted at your facility from 6/6/10 to 8/6/10, in accordance with 42 CFR, Chapter IV, Section 482.1 to 482.57.</p> <p>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions, or other claims for relief that may be available to any party under applicable federal, state, or local laws.</p> <p>The complaint investigative process was initiated by the Bureau of Health Care Quality and Compliance on 6/8/10 in cooperation with the Las Vegas Metro Police Department.</p> <p>The investigation included:</p> <ul style="list-style-type: none"> -Observations of the Neonatal Intensive Care Unit (NICU). Observations verified the NICU Pods were kept secured and only authorized personnel were allowed entry. Observations were made of cameras at the entrance of each NICU Pod and new cameras were installed above each Isolate in the NICU Pods. -Interviews were conducted with the NICU Medical Director, Director of Regulatory Compliance and Patient Safety, Quality Management Coordinator, Vice President of Human Resources, 3 Staff Nurses, Respiratory Therapist, Vice President of Quality Medical Staff and Director of the NICU. -Review of thirteen (13) medical records of patients with disrupted Peripherally Inserted 			A 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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A 000	<p>Continued From page 1</p> <p>Central Venous Catheter (PICC) lines and one (1) medical record of a patient with a disrupted Umbilical Arterial Catheter (UAC) line was completed.</p> <p>-Review of Policies and Procedures which included: General Standards of Practice Guidelines for NICU, Job Descriptions and Requirements for NICU nurses, PICC line insertion and removal, UAC placement and removal, Staff background checks and requirements for employment, Security in the NICU.</p> <p>Complaint #NV00025458 allegation was substantiated; however there was no regulatory deficient practices identified through observations, document review, clinical record review or interviews with staff.</p> <p>The facility had processes in place to ensure the safety and well being of the patient's in the NICU. The hospital has taken appropriate actions to prevent the possibilities of similar events from occurring in the future. The facility had identified a spike with PICC line disruptions in the NICU and took action by in-service of staff and investigating whether the disruptions were due to product error. The Medical Director of the unit was involved to identify the problem and to assist the risk management group in setting up systems to prevent further occurrences. The facility changed the manufacturers brand of IV tubing and filters used on the unit. Staff was changed in the NICU Pods and two licensed staff were on the unit at all times. An outside forensic expert was also hired by the facility to determine the cause of the PICC line disruptions. After a disruption occurred of a patient's UAC line, the facility immediately notified</p>	A 000			

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A 000	<p>Continued From page 2</p> <p>Las Vegas Metro Police Department, who initiated their investigation. The State Board of Nursing and the Bureau of Health Care Quality and Compliance were also notified of the incidents. The facility filed form 3500 with the U.S. Food and Drug Administration regarding the issues of the PICC line disruptions and the incident with the UAC line. The facility suspended four staff on duty at the time the UAC incident had occurred in the NICU pending the investigation. Cameras were installed above each isolate in the NICU to further increase security and protection of the patients.</p> <p>No further action is necessary. Please retain a copy for your records.</p>	A 000			